10 August 2017

Wendi Ogle-Welbourn, Executive Director of People and Communities, Peterborough City Council
Ms Jill Houghton, Chief Nurse for NHS Cambridgeshire and Peterborough CCG
Ms Sarah Hamilton, Designated Nurse, Safeguarding Children for NHS Cambridgeshire and Peterborough CCG
Dr Emilia Wawrzkowicz, Designated Doctor, Safeguarding Children for NHS Cambridgeshire and Peterborough CCG
Jason Ablewhite, Police and Crime Commissioner
Alec Wood, Chief Constable of Cambridgeshire Constabulary
Steve Johnson-Proctor, National Probation Service, Divisional Director
Emma Osborne, Community Rehabilitation Company, Regional Chief Executive
Iain Easton, Youth Offending Service Manager
Russell Wate, Chair of Peterborough City LSCB

Dear **local partnership**

**Joint targeted area inspection of the multi-agency response to abuse and neglect in Peterborough City Council**

Between 26 and 30 June 2017, Ofsted, the Care Quality Commission (CQC), HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and HM Inspectorate of Probation (HMI Probation) undertook a joint targeted area inspection (JTAI) of the multi-agency response to abuse and neglect in Peterborough City Council.[1]

This letter to all the service leaders in the area outlines our findings about the effectiveness of partnership working and about the work of individual agencies in Peterborough.

This JTAI includes an evaluation of the multi-agency 'front door' for child protection, when children at risk become known to local services. In this inspection, the evaluation of the multi-agency 'front door' focused on children of all ages who are being or have been neglected. The JTAI also included a 'deep dive' focus on children between seven and 15 years old who have been neglected. This group of children will be referred to as 'older children' for the purpose of this letter.

A strong multi-agency partnership coordinated by the Peterborough Safeguarding Children Board (PSCB) works effectively to deliver services for children in Peterborough. Senior leaders recognise that the current arrangements at the 'front door' do not

[1] This joint inspection was conducted under section 20 of the Children Act 2004.

provide a sufficiently resilient multi-agency response for all children. As a result, plans to introduce a fully integrated multi-agency safeguarding hub (MASH) with Cambridgeshire are well advanced and will become fully operational in July 2017. The move by all partners across Peterborough and Cambridge to co-locate will support agencies to work together more effectively to safeguard children, as it will provide greater opportunities for increased joint working.

Children who are suffering from neglect are identified by professionals and referred for assessment of their needs and additional support. The rates of referrals for children identified as suffering from neglect are consistently higher in Peterborough than the England average. The rate of children becoming subject to child protection plans under the category of neglect is currently 68%. This is a slight reduction on last year, but still consistently well above the England average of 43.8% (March 2016). There is a good understanding of the complex and changing demographics of the city, and what this means in relation to the needs of children and families. A combination of factors means that there are challenges in delivering services to children who experience neglect. There are neighbourhoods within the local authority with significant deprivation, diverse populations, and some established and more recently arrived families from minority ethnic communities. There is also a growing population of young people, at 40% of children in primary education, who speak English as their second language.

The PSCB has led the development of a multi-agency neglect strategy that was launched in September 2016. The strategy is supported by extensive resources, including a 'neglect assessment toolkit', and was published alongside a revised thresholds document. In May 2017, the board coordinated a multi-agency audit of the work carried out with children suffering from neglect to ensure a good understanding across the partnership of frontline practice, including areas for improvement. However, the partnership has not developed good-quality action plans to implement change and monitor improvement. Its ability to monitor progress effectively is also limited because there is a lack of relevant performance information. For this reason, the impact of the strategy on operational work with children is limited. Currently, there is too little improvement in levels of awareness of neglect, and limited effective use of resources and tools to identify its impact among frontline practitioners.

This theme of good strategic cooperation and involvement not translating into robust, outcome-focused planning is also seen in the work of frontline staff. Despite strong partnership involvement at multi-agency meetings and cooperation to deliver many good-quality services, there is not enough improvement for many older children who are suffering from neglect. Planning and intervention often lack focus and impact. Assessments do not address the underlying causes or impact of neglect, and care planning is not outcome focused, clear or measurable. As a result, some children are experiencing neglect for too long before any change takes place.

## Key strengths

The PSCB has started to support partners to understand and focus on the specific risks to older children suffering neglect. The board has identified the further work needed to develop links between the strategy around neglect and work with children at risk of criminal exploitation and from gangs. The board has also facilitated learning, through presentations of research, regarding the links between neglect and child sexual exploitation.

A multi-agency audit of cases of neglect was completed in May 2017 to review the impact of the strategy on work with children. This resulted in the partnership identifying some strengths, as well as many areas of practice that require improvement to ensure that children experiencing neglect are responded to effectively. Similar findings from the audit were also identified during this inspection, providing evidence that the partnership has gained an accurate understanding of progress to date in this area of work.

Strong leadership and a well-coordinated system of support from the local authority are enabling lead professionals from a wide range of agencies, particularly schools, to undertake early help assessments and deliver some effective interventions for children suffering from neglect. A wide range of effective in-house and commissioned services, targeted to meet specific needs, support this.

Most children referred to the MASH are appropriately triaged and signposted to the right services, despite the current limitations of staff being based across two sites. Police staff in the MASH process most referrals made to children's services in a timely manner. The National Probation Service (NPS) and Community Rehabilitation Company (CRC) are also both committed to providing the MASH with timely information, and they have set up mirror administrative processes to enable their organisations to respond quickly to MASH requests for information about known offenders. Youth offending service (YOS) managers quality assure all referrals to the MASH hub prior to submission in order to make sure that they contain relevant information, meet the threshold for referral and enhance the timeliness of action to support children experiencing neglect.

The health practitioner in the MASH provides a valued and robust contribution to multi-agency strategy discussions and is a key influencer in multi-agency decisions. Agencies are committed to the future improvement of the multi-agency arrangements.

Vulnerable unborn children are identified early through coordinated multi-agency sharing of information. This sharing of information provides opportunities for relevant agencies to support parents and safeguard children.

The quality of children and family assessments in children's social care is improving. Recent better-quality work includes more effective identification of children's individual needs and of their cultural and identity needs. The best examples of this work are appropriately analytical of presenting concerns, including neglect.

When children are assessed as being in need of help and support, they are the subject of multi-agency child in need plans, led by support workers who bring a range of appropriate knowledge and skills. This ensures that effective services are offered to support children who are experiencing neglect. This work is overseen, supported and reviewed by experienced, qualified social workers and managers, who authorise plans.

Practitioners who work with children spend time building relationships with them to understand their views. When there are larger brother and sister groups, workers engage with each child effectively to reach an understanding of their needs as part of the family. Schools undertake effective work with children, and ensure that their views are captured and represented when plans are made to reduce the neglect.

Young people have good access to child and adolescent mental health services (CAMHS) for assessment and treatment. The core and neuro-developmental CAMHS services routinely beat targets for waiting times for assessment and treatment, and there has been a significant improvement in performance over the past 12 months. The service is child focused in its delivery and case recording. Children are seen alone, and clinicians and practitioners prioritise and capture the voices of the children, routinely quoting children's wishes and views in the case records.

All general practitioner (GP) practices have an identified link health visitor, and most hold regular multidisciplinary meetings to share information and discuss children and families known to be vulnerable or at risk. These meetings include discussions regarding families where neglect has been identified, and this means that vulnerable children and families can be signposted and be engaged through early help and support in a timely way.

Adult mental health services have recognised the challenge that the case recording system presents in supporting effective work with families. The service has customised the system to ensure that any children linked to the adult client are immediately identified when the case record is accessed. Adult mental health services are making good use of the children safeguarding module, which is part of the adult mental health assessment. This supports practitioners well in keeping the profile of children high, enabling practitioners to prioritise the safeguarding of children while working primarily with the adult.

The adult substance misuse service has a particularly good understanding of neglect and its impact on children. Parents who are using the service, and whose children are experiencing or are at risk of neglect, have been able to access a bespoke service that

provides emotional support. Parents and children report really valuing the support that they have received, which has improved the experiences of children at risk of neglect.

Protection of the vulnerable is a priority for Cambridgeshire Constabulary and the police and crime commissioner (PCC), as outlined in the police and crime plan. There is a communications strategy that highlights to staff different types of neglect and what their responsibilities are around this issue. It is too early to know whether this has improved understanding and how it may affect potential outcomes for children. Over the past two years, there has been an increase in staff within the MASH and public protection, illustrating that these services are regarded as important. The constabulary's review of demand will inform where and when service change is required and the level of resource needed to meet this demand. There is a recognition that any changes in service delivery and staffing will need to be made in consultation with other partners to ensure that the current relationships and joint working are maintained and enhanced.

Safeguarding has remained a strategic priority for the NPS and CRC through a complex period of organisational transition. Progress in implementing the NPS action plan, drafted as a result of its audit, is monitored and indicates improved practice. Both organisations monitor and encourage attendance at child protection conferences and child safeguarding training, and the vast majority of practitioners have completed their training at level 1 or 2. The CRC has commissioned a range of appropriate interventions to support families and parenting, and these have made a difference to children.

The YOS's strong focus on neglect has been enhanced not only through its work to understand and address the increasing risks posed by gangs, but also through its contribution to the development of a targeted youth support service. YOS practitioners understand and recognise signs of neglect and have access to a range of specialists, which enhances their response to neglect. The emotional and mental health team within the YOS provides screening on a range of presenting issues and delivers effective preventative interventions to help children to manage their behaviour and improve their psychological and emotional well-being.

The health safeguarding group provides strong leadership to coordinate safeguarding activity and promote good practice among health staff. It also provides the means to challenge performance when shortfalls are identified. The group has directed the action plan that is derived from the recent children looked after and safeguarding review carried out by the CQC, and this has resulted in improvements in a number of key areas, which in turn have led to better outcomes for children and families.

Supervision and quality assurance of referrals and of information submitted for child protection conferences are generally strong in health services. This is particularly the case in maternity services and the substance misuse service, where frontline supervisors check each referral and information submission for detail and quality. Such

practice supports good decision-making in an area where health services information is a key feature.

There is a consistently good picture of supervision and safeguarding training across health services, and staff are well supported. For example, safeguarding training in adult mental health has been strengthened over the past year. The named nurse for safeguarding children in primary care provides highly visible leadership and support to GPs. This work is supported by the comprehensive 'safeguarding children and young people information resource pack' and has led to a general uplift in the effectiveness of safeguarding practice of GPs. One GP practice has demonstrated outstanding end-to-end processes for managing safeguarding information.

Strong strategic and senior leadership in the local authority provides a clear direction for services for children, including those experiencing neglect. Recent changes to strategic leadership, because of integrated arrangements between Peterborough and Cambridge, have been suitably risk assessed to ensure that there is sufficient leadership capacity for local services. Senior leaders demonstrate an open and positive attitude to challenges, feedback and learning, which supports continuous improvement in services for vulnerable children. Leaders know their services well and have an accurate understanding of the quality of practice, including in relation to neglect.

A focus on improved recruitment and retention has led to increased stability in the workforce. As a result, many social workers know children well, and many have been able to build and sustain effective working relationships with children and their families. Senior leaders identify areas of practice that require improvement, and ensure that training and development opportunities are made available to support staff to make the required changes.

Local authority leaders are committed to improvement through identifying new and creative ways of working. The recent successful innovation fund bid has secured £2.8 million to work with Hertfordshire County Council to implement a family safeguarding model. This will involve the development of multidisciplinary teams situated within children's social care, and will include adult mental health, substance and alcohol misuse and domestic abuse practitioners. They will work alongside children's social workers to develop a single-family plan for families with the most complex needs. The approach is targeted at families with younger children subject to child protection plans, and will clearly have potential benefit for children suffering from neglect.

The local authority has also recognised that older children at risk of exploitation because of neglect would benefit from a child-centred, relationship-led and multi-agency response to their often very complex needs. As a result, the local authority is currently consulting with staff and partners as part of the development of a targeted youth support service to include staff from youth services, YOS, education services and social care.

**Case study: highly effective practice**

**Involvement of adult substance misuse service in multi-agency working and keeping children safe.**

The adult substance misuse service is effective in contributing to the safeguarding of children experiencing neglect in Peterborough. Regular risk assessments by the service show consideration of the impact of adult behaviours on children and how these behaviours contribute to neglect. Workers are providing effective one-to-one support or access to community groups for children who are living in households where there are parents who misuse substances. Professionals and parents reported access to these resources positively. Young people had remained engaged in the activities, despite a picture of disengagement from other services and activities.

One particularly strong case example was from a practitioner who was working with a parent who was prescribed methadone. The dose was usually collected daily from a local pharmacy but, during a bank holiday period, the pharmacy was closed and the medication needed to be stored at home. The practitioner completed a home visit to review the safe storage of the medication in the box provided by the service. The observations of the practitioner of the interactions between mother and children are recorded in the case record. The risks of medication being stored at home and of the neglect that the child was experiencing were clearly documented in the practitioner's records. The risks were explicit and were shared with the professional network after the home visit. This meant that other professionals were more alert to the increased risk to the child over this time, and home visits could review these risks and respond appropriately.

## Areas for improvement

### Identifying and managing risk of harm at the 'front door'

Social work decision-making in the MASH is not always informed by the effective evaluation of children's history or consideration of their lived experience. This means that some older children suffering neglect do not have their needs fully considered. In some less high-risk cases, key information from partners is not always gathered to inform decisions and plans for children, and agencies do not consistently get feedback to keep them informed.

Records of strategy discussions do not always include clear safety plans to address immediate concerns and reduce risks while waiting for a child protection conference and multi-agency plan.

Children and family assessments are not regularly updated, therefore risks and needs are not always clearly understood. This leads to ineffective planning and drift for some children. Management oversight of casework does not always drive progress in neglect cases. Some cases considered by inspectors have been stepped down from child protection too early, before sustainable change is realised and improvements are made for children. Workloads in assessment teams mean that the time that social workers can spend directly with families is limited. They manage competing priorities and, as a result, too many case records have little information about children and their views.

Police officers do not routinely record the views of children in records or referrals, and the forms used do not provide prompts to ensure that they do this. Neither are officers clear about what action they should take when attending incidents where children are subject to a child protection plan. This means that opportunities to gather evidence and take steps to safeguard the most vulnerable children are being missed.

There has been little formal training of police officers and staff around neglect, and many do not have the necessary level of understanding to identify neglect and make well-informed decisions. To address this gap, two training events were held in May 2017 with a particular focus on neglect. This has not yet translated into improved knowledge and decision-making.

Health visitors carry out detailed observational recording when they undertake home visits, but they do not routinely evaluate and analyse risk or the impact of this on the child. The school nurse service lacks capacity, and practitioners are struggling to sustain current levels of child protection work and provide high-level support in complex cases. The locally agreed target of undertaking the health assessments requested by initial child protection conferences within 10 days is not being achieved. This means that some children of school age do not have their health and well-being needs identified and met in a timely way.

While GP participation in child protection conferences is improving following actions prompted by the PSCB, GPs' use of the child protection information-sharing template is inconsistent. This means that there is variation in the quality of information that GPs submit and to what extent it informs child protection conference decisions and planning.

Dental practices have safeguarding processes and lead roles in place, and are well aware of the importance of dental health as an indicator of potential neglect. Practices visited are keen to be better engaged with local child safeguarding arrangements, and to participate and contribute to child protection case conferences and child protection planning. However, they describe themselves as being 'out of the loop', currently. Opportunities for them to be part of the multi-agency child protection team are being lost. Other than the community dental service, which routinely makes child protection referrals to MASH, dental practices in Peterborough are not making early help or safeguarding referrals. Practices recognise that the level of safeguarding training undertaken by clinicians and staff is not sufficiently equipping them in their day-to-day work with children and families.

**Response to children living with neglect**

Strategy meetings are not always held quickly enough in response to new or escalating risks for children who are already the subject of plans and intervention. Strategy meetings held on open cases often only involve the police and a social worker. This means that some children do not benefit from information from the multi-agency group working with the family.

Assessments identify the main areas of risk, but do not offer good analysis of the impact of ongoing and historic neglect on children. In many cases, the impact of parents' behaviour on children is considered but is not thoroughly analysed and, in some cases, this could be articulated by workers but was not recorded well on case files. This means that there was not a clear written analysis to inform multi-agency planning. There was no evidence of practitioners using the tools provided by the PSCB to evaluate neglect and inform assessments, which would have given a clearer picture of children's experiences.

All older children have written multi-agency plans which are focused on the risks to the children because of the neglect that they were experiencing. However, many older children are neglected for too long without effective action being taken. Plans are not clear about the desired outcomes or about how the partners will measure improvements. This leads to delays in taking decisive action, and many cases were allowed to drift without professionals having a real understanding of whether current risks were reducing or whether improvements were sustainable. Partners are not challenging each other enough within multi-agency core groups or child in need meetings, and the escalation process is not used effectively to challenge or ensure that change takes place.

**Leadership and management and the Local Safeguarding Children Board**

Despite neglect being a shared strategic priority, this has not been effective within all agencies at raising awareness. Some frontline practitioners, particularly those in schools, remain unaware of the strategy and, within the majority of agencies, there is a limited increase in understanding and little use of the resources and tools provided. This means that not all children and young people suffering neglect may be identified and their needs are not properly understood.

The safeguarding board has not yet put in place robust SMART (Specific, Measurable, Achievable, Realistic and Timely) planning or effective performance management to understand and monitor impact and improvement across the partnership. Despite the neglect strategy outlining how impact would be measured, this has not been possible due to a lack of relevant performance data across agencies.

The multi-agency audit undertaken in May 2017 identified that the ability of agencies to undertake their own quality assurance was variable and needed improvement. The disparity between the quality of audits from partner agencies resulted in the process being heavily driven by social care. For this reason, the multi-agency evaluations produced for this inspection were undertaken in a collaborative way, with one evaluation produced for each child by the partnership. Despite this, the evaluations were variable in quality, did not identify all gaps in practice, and were very focused on measuring activity and process rather than evaluating outcomes. It was often not clear from reading the evaluation document what the partnership thought about the quality of practice or the services provided for children.

Although audits undertaken by the partnership prior to this inspection identify many areas of improvement and make some recommendations, these have not translated into focused action plans that can drive change and improvement across the partnership. As a result, despite the learning, impact is limited in improving services for children.

There are missed opportunities to understand the quality of practice in some significant areas of work with children suffering from neglect. There is robust quality assurance by the early help service at the point at which assessments are completed, but this information is not collated or reported back to the partnership to enable leaders to understand their own agency performance.

The ability of the local authority to manage performance effectively continues to be inhibited, because of a lack of progress in developing the effective suite of performance data. Despite a clear recommendation made following an inspection in

2015 that reliable information needs to be developed and made available to managers, this has not yet been fully addressed. Team managers do not yet have access to appropriate performance reports and staff in the early help service are continuing to use manual systems to produce key information.

Management oversight and supervision are not yet effective in driving the quality of practice, and this is resulting in drift and delay for some children suffering from neglect.

The level of knowledge and proactivity at management level varies in both the CRC and NPS. Probation practitioners are not focused enough on neglect, they do not generally understand or are not fully up to date on the LSCB neglect strategy and there are inconsistencies in the quality of frontline practice. Neither the NPS nor CRC are involved in initial MASH strategy meetings. There are also ongoing issues with referrals that do not consistently meet the needs of either the MASH or probation services. Neither the NPS nor CRC has a mechanism in place for assessing the quality of referrals to children's social care or the response to their referrals, reducing their ability to agree a solution with the MASH and negatively impacting on services to safeguard children.

While there is evidence of strategic leadership and direction within the police, this has not yet translated into consistent improvements in operational delivery. A programme of awareness raising is being delivered to frontline staff, but those spoken to by inspectors had not received it and had a limited understanding of neglect, although they had some knowledge of wider vulnerability. There is also a limited understanding of the importance of the voice of the child, and too often this is not sought or recorded.

The attendance of police representatives at initial child protection conferences is currently insufficient, and this has been attributed to heavy workloads. Cases are not risk assessed to identify those that most require police attendance when there are limited resources available to attend. There is an action plan to improve attendance and ensure that this issue is more visible to senior managers, using management information to allow greater scrutiny.

Audit of the quality of decision-making is underdeveloped within the police, and senior leaders cannot be assured that staff within the MASH and on the frontline are consistently making the best decisions for vulnerable children in all cases. A sound audit process would also highlight issues such as recording of meetings and other relevant information on police systems, which has been found to be lacking in some cases. Effective management data and audit processes would also provide an opportunity to assess the quality of the child at risk forms completed by officers and staff, focus the training and monitor the improvement.

The constabulary recognises the need to develop meaningful management and performance data to enable clearer understanding of where improvement is needed, and the impact of activities that it undertakes to improve outcomes for children. There is currently no regular review of data relating to neglect, as this is not routinely collected.

Although safeguarding information management processes for health providers have generally improved though the work of the clinical commissioning group (CCG) and the full-time named safeguarding nurse for primary care, there is still some work to do to ensure that these are developed properly in all GP practices. In one of the four practices visited, the newly implemented monthly meeting with health visitors is not supported by an information management process. As such, its effectiveness in safeguarding vulnerable children in the practice list is limited by a lack of structure and coordinated activity.

**Case study: area for improvement**

**The multi-agency partnership, coordinated by the PSCB, needs to ensure that robust systems are in place to evaluate and monitor performance, hold agencies to account and drive improvement.**

The partnership, supported by the PSCB, works well together to consult and collaborate on new initiatives such as the development of the MASH and the neglect strategy. However, as part of this development, there is not enough focus on ensuring that robust performance management and quality assurance are in place to ensure that, once established, the effectiveness and impact can be measured.

The PSCB neglect strategy contains clear information about how progress is be monitored and measured but, eight months after its launch, only some of the measures are in place and being measured. As a result, there is no clear understanding about the lack of progress in awareness raising or the use of resources or tools until the audit work was undertaken. Insufficient attention during development of the strategy led to a set of performance measures being agreed, several of which are not yet available to consider or are as yet not possible to produce.

The multi-agency audit of cases of neglect identified that some agencies could not produce effective audits of their own practice. Not all partners have established effective systems to evaluate their own practice or report this effectively to the PSCB.

Once single-agency or multi-agency audits identify areas for improvement or make recommendations, the subsequent action plans are not strong enough and need clearer outcomes and measurable targets that the partnership can use to effectively monitor and drive progress.

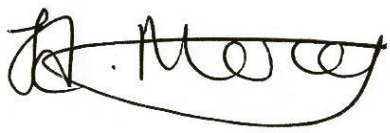
Stronger strategic plans would demonstrate to frontline staff and managers what effective action planning looks like and could support an improvement in the quality of the planning for children who are experiencing neglect.

## Next steps

The director of children's services should prepare a written statement of proposed action responding to the findings outlined in this letter. This should be a multi-agency response involving NPS, CRC, CCG, and health providers in Peterborough and Cambridgeshire Police. The response should set out the actions for the partnership and, where appropriate, individual agencies.[2]

The director of children's services should send the written statement of action to ProtectionOfChildren@ofsted.gov.uk by 14 November 2017. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Yours sincerely

| **Ofsted** | **Care Quality Commission** |
|---|---|
|  <br>Eleanor Schooling<br>National Director, Social Care |  <br>Ursula Gallagher<br>Deputy Chief Inspector |
| **HMI Constabulary** | **HMI Probation** |
|  <br>Wendy Williams<br>Her Majesty's Inspector of Constabulary |  <br>Helen Mercer<br>Assistant Chief Inspector |

[2] The Children Act 2004 (Joint Area Reviews) Regulations 2015 www.legislation.gov.uk/uksi/2015/1792/contents/made enable Ofsted's chief inspector to determine which agency should make the written statement and which other agencies should cooperate in its writing.